| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.610a)<br>300.1210b)<br>300.1210d)6)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br><br>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.<br><br>Section 300.1210 General Requirements for | S9999 | Attachment A<br>Statement of Licensure Violations | |

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| S9999 | Continued From page 1<br>Nursing and Personal Care<br><br>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:<br><br>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.<br><br>These regulations were not met as evidenced by:<br><br>Based on observation, record review and interview the facility failed to follow fall prevention interventions for one of nine residents (R2) reviewed for falls in the sample of 18. This failure resulted in R2 sustaining a fall with a femur fracture and subsequent above the knee amputation.<br><br>Findings include:<br><br>R2's current electronic facesheet documents the following diagnoses: "Arthropathy, traumatic lower leg, Note: right knee (dated 7/6/15); Above knee amputation status (dated 7/6/15); Arthropathy, traumatic pelvic/thigh, Note: right (dated 3/26/15); and Aftercare, heal traumatic fracture hip, Note: right (dated 3/26/15). | S9999 | | |

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The facility's Emergencies policy (revised 5/2014) documents the following: "Falls: Check the resident immediately for ability to move extremities; check for bruised areas and/or cuts... Check resident's ability to explain what happened; evaluate resident's condition before the fall... Check if, or with anyone who witnessed the accident. Determine, if possible, where, how, and when the accident occurred... Check for any apparent discoloration or possible fracture..."

The facility's Care Plan Policy and Procedure (revised 11/2013) documents the following: "The care plan meeting provides a framework for providing good resident care and sets direction for meeting the needs of the individual resident... Secondly, it provides a valuable communication tool for staff to ensure that individual plan of care is carried out... Care plans are available to clinical staff online in the (Electronic Health Record). All non-clinical staff members are to contact the nurse for access to the care plan as needed. "

R2's care plan (dated 10/15/2015) documents the following: "Problem start date: 3/26/2015. (R2) is at risk for falls related to dementia and osteoporosis, as well as, history of falls and hearing impairment... Approach start date: 4/28/15. Assist R2 with toileting needs, upon rising, before and after meals, and at bedtime to reduce incident of falls associated with toileting needs... Approach start date: 3/26/15. Alternate call system... Approach start date: 3/26/15. Floor mats at bedside when in bed."

R2's Event Report (dated 7/2/15) documents the following: "Description: Fall... Location of Fall: Resident bathroom... What was resident doing just prior to fall: propelling self in wheelchair...

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| S9999 | Continued From page 3<br><br>Why does resident think they fell: 'I (R2) was trying to clean my butt'... Was fall witnessed: No... Does resident exhibit or complain of pain related to the fall: Yes (location)- right knee/leg... Positioning of extremities: rotation/deformity/shortening of right lower extremity."<br><br>R2's Investigation Report (dated 7/3/2015) documents the following: "Interview with (E14, Certified Nursing Assistant). I (E14) had gotten (R2) up about 2:45 PM. I (E14) think it was about that time. (R2) was trying to get out of bed when we went by the room so I (E14) washed (R2) up and got (R2) up to (R2)'s wheelchair, I (E14) brought (R2) out of (R2)'s room and (R2) was propelling around the halls after that, I (E14) couldn't leave (R2) in (R2)'s room, (R2) is a fall risk... I (E14) did not toilet (R2) when I (E14) got (R2) up, (R2) goes right before supper, usually (R2) will tell you when (R2) does not want to go. I (E14) do not know if (R2)'s bathroom door was open or shut, but I (E14) have seen (R2) open it."<br><br>R2's Investigation Report (dated 7/3/15) documents the following: "Interview with (E21, Registered Nurse, previously employed by facility during occurrence). I (E21) think (R2) could've opened the bathroom door, I (E21) don't know if it was propped open or not. I (E21) think (E14) had just gotten (R2) up shortly before it happened and (R2) was propelling around the halls... When I (E21) got to the bathroom, (R2) was laying on (R2)'s back, head towards the shower, the toilet riser frame was in place and (R2) was lying supine with (R2)'s left foot and leg extended and (R2)'s right leg flexed, (R2)'s right foot was between the toilet riser frame and the toilet, (R2)'s leg was externally rotated..." | S9999 | | |

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R2's Investigation Report (dated 7/2/15) completed by E2 (Director of Nursing) documents the following: "Writer (E2) summoned to (R2)'s bathroom per (E21) for evaluation of (R2). (R2) was lying on back with head towards west (shower) and feet alongside of inner toilet at wall side, left leg extended and right leg flexed. (R2) complaining of right knee pain and unable to straighten, maintained flexed with pillow support... (R2)'s wheelchair was noted to be nearby, toilet riser had been removed before writer (E2) summoned to room. (E21) stated (R2)'s right foot was between toilet and riser. (R2)'s clothing was in place and (R2) was not able to be moved due to immediate complaints of pain when right knee indicated or questioned about, knee appeared swollen and discolored. (R2) unable to state purpose, intent, details of event at this time. Recommended (Emergency Medical Services) transfer to (Emergency Room) per (R2)'s complaints of pain and swollen appearance of (R2)'s right knee.

R2's local Emergency Room report (dated 7/2/15) written by Z1 (Emergency Department Physician) documents the following: "Course Progress: X-ray of the knee shows what appears to be a supracondylar fracture just at the level of the proximal portion of the knee prosthesis with dislocation of the prosthesis..."

R2's Consultation report from a local hospital (dated 7/3/15) written by Z2 (Orthopedic Surgeon) documents the following: "Reason for consultation: Right knee supracondylar periprosthetic femur fracture... (R2) apparently fell at the nursing home and was brought to the emergency room and found to have a distal femur fracture below a (prior) femoral revision stem and above a cemented total knee

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arthroplasty... I (Z2) had a lengthy discussion with (Z3, R2's family member) who is the power of attorney about (R2)'s condition. The options would be to treat this in a cast or knee immobilizer versus an open reduction internal fixation versus a conversion of the total knee arthroplasty to a cemented hinged knee type of arthroplasty. The pros and cons were discussed with (Z3). The cast and immobilizer would most likely be very painful to (R2) and it would make it very hard to care for (R2) as far as sitting (R2) up and getting (R2) into a chair. The option of trying to perform an open reduction internal fixation would be very difficult given the extent of (R2)'s osteoporosis and difficult to do a hinged total knee arthroplasty. The last option would be to perform an above the knee amputation. This would allow good patient care and hygiene. (R2) would have a lower chance of developing complications from not being able to mobilize (R2) such as decubitus ulcers and pulmonary conditions such as pneumonia. (Z3) did appear to understand. (Z3) discussed it with family and opted to go with an above the knee amputation. (Z2) will plan to do this."

On 10/19/15 at 12:15 PM, R2 was sitting in R2's wheelchair with R2's right above the knee amputation stump resting on R2's wheelchair seat.

On 10/20/15 at 12:00 PM, E8 (Certified Nursing Assistant) and E9 (Certified Nursing Assistant) used a mechanical lift to transfer R2 from R2's bed to R2's wheelchair. E8 provided support to R2's right above the knee amputation during R2's transfer.

On 10/21/15 at 2:35 PM, E14 (Certified Nursing Aide) stated that on 7/2/15, E14 got R2 up from

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bed at 2:45 PM and performed perineal care. E14 verified that E14 did not toilet R2 at the time E14 got R2 up from bed. E14 stated that E14 then took R2 to the facility's day room because R2 was not supposed to be left unattended. E14 stated that R2 self-propelled back to R2's room and attempted to toilet independently. R2 then sustained a fall.

On 10/21/15 at 11:30 AM, E2 (Director of Nursing) verified that R2's care plan at the time of R2's fall indicated that facility staff were supposed to toilet R2 upon rising from bed and before and after meals. E2 stated that E14 did not toilet R2 upon R2 getting up from bed at on 7/2/15 at 2:45 PM and if R2 had refused to be toileted, E2 would expect that E14 would have offered to toilet R2 again.

On 10/22/15 at 12:35 PM, E24 (R2's Physician/Medical Director) stated that R2 sustained a right femur fracture as a result of R2's fall on 7/2/15. E24 stated that R2 had a prior right knee surgery and right prior hip surgery, and this femur fracture was located just above R2's previous right knee surgical hardware. E24 stated that due to the site of the right femur fracture sustained on 7/2/15, it was difficult to surgically repair and therefore it was decided that R2 would have a right above the knee amputation. E24 also stated that if R2 would not have fallen and sustained this right femur fracture, R2 would not have required a right above the knee amputation.

(B)